Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

DIRECTIVE NO.: 2-2012

TO: **ACCIDENT AND HEALTH INSURERS, HEALTH MAINTENANCE ORGANIZATIONS, HOSPITAL MEDICAL SERVICE CORPORATIONS, AND OTHER INTERESTED PERSONS**

FROM: **ARKANSAS INSURANCE DEPARTMENT**

SUBJECT: **SELECTION OF ARKANSAS'S ESSENTIAL HEALTH BENEFITS BENCHMARK PLAN**

DATE: **SEPTEMBER 21, 2012**

The Arkansas Insurance Department ("Department") issues this Directive pursuant to Section Four (4) of Arkansas Insurance Department Rule 103, "Essential Health Benefits Benchmark Plan" ("Rule 103"). Under Section Four (4) of Rule 103, the Arkansas Insurance Commissioner ("Commissioner") is required to select a benchmark health plan for the purpose of establishing essential health benefits ("EHB") for health plans subject to Section Two (2) of Rule 103. The purpose of this Rule is to comply with requirements issued by the Department of Health and Human Services ("HHS") for states to select a benchmark health plan before September 30, 2012, to serve as the standard for providing EHB in non-grandfathered health plans offered through the Exchange operating in the State as well as to non-grandfathered plans offered in the individual and small group markets outside the Exchange in the State.

The Commissioner's selection is for a two (2) year period governing the initial essential health benefits benchmark plan for coverage years 2014 and 2015 on or before September 30, 2012.

Section Four (4) of Rule 103 states that "the Commissioner shall issue his or her decision as to the EHB benchmark plan and the reasons therefore, through a publicly issued Directive or Bulletin within ten (10) days following submission of a report to the Commissioner from the Arkansas Health Benefits Exchange Partnership Division (HBEPD) which shall include the data and recommendations related to the factors set out in Section Four (4) (A) through (J) of Rule 103."

On September 17, 2012, the Commissioner received the report from HBEPD. After consideration and review of the report from HBEPD, the Commissioner hereby adopts the following report and recommendations in full and incorporates them by reference in this Directive.

REPORT & RECOMMENDATIONS

To: Commissioner Jay Bradford
From: Cindy Crone, HBEPD Director
Date: September 17, 2012
Subj: Essential Health Benefits Benchmark Recommendation

Based on thorough study, strong stakeholder involvement, consumer benefits and cost, and compliance with ACA and Arkansas Insurance Department Rule 103, the Health Benefits Exchange Partnership Division makes the following recommendation for Arkansas's Essential Health Benefits Benchmark Plan:

> Arkansas Blue Cross Blue Shield Health Advantage Point of Service (POS) Plan with the following supplementation:
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> • QualChoice Federal Plan Mental Health and Substance Abuse Benefits due to the BCBS Health Advantage plan benefit not being sufficient to meet the requirement under federal mental health parity law;
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> • Arkansas Child Health Insurance Plan (CHIP), AR Kids First for Pediatric Dental benefit as a pediatric dental benefit is absent from the BCBS Health Advantage plan;
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> • Arkansas Blue Cross Blue Shield Federal Pediatric Vision Plan (BCBS Blue Vision – High) due to this being the federal plan with the highest enrollment, and Arkansas's only supplemental option.

It should be noted that DHHS has announced that the new Habilitative Services benefits will be chosen by the carriers with Arkansas Insurance Department having the power to reject the benefit filing if habilitative services are not covered in a way that follows the spirit of the federal law.

REQUIREMENTS FOR CHOOSING AN ESSENTIAL HEALTH BENEFIT BENCHMARK PLAN

The Affordable Care Act (ACA) and subsequent rules and bulletins from the Federal Government have directed states participating in a State Based Exchange or a Federally

Facilitated Partnership Exchange that has opted to maintain control over plan management functions to select a "benchmark plan" from federally established benchmark plan options. There are seven options for the Arkansas benchmark to establish the Essential Health Benefits (EHB) which must then be provided by all individual and small group plans both inside and outside of the Exchange. Moreover, the Arkansas Insurance Department has recently adopted, with legislative approval, Rule 103 which describes the process by which the Arkansas Insurance Commissioner is to select the benchmark plan for Arkansas. The benchmark plan must contain the ten essential health benefits that are enumerated in the ACA, supplementing from another benchmark plan only if an essential health benefit is missing. The Commissioner is also directed to review the balance of all plan benefits to ensure that plans remain affordable while benefits are not weighed more heavily in any category or toward any particular segment of the Arkansas population. The Commissioner must weigh the capacity of the health plans to provide the EHBs and how the benchmark plan provides and advances consumer protection in Arkansas. The Commissioner must take into consideration any recommendation made by the Plan Management Advisory Committee, the Steering Committee, public and healthcare industry comments and recommendations of actuaries related to these selections. If the Commissioner fails to make a determination by the third quarter of 2012, the federal government will automatically choose the state's largest small group plan by enrollment to be the initial benchmark plan for the state.
As part of the affordability consideration, the Commissioner must weigh factors such as whether the selected EHB benchmark plan includes state mandated benefits. If any state mandated benefit is not named as an EHB, the state must defray the cost relative to that benefit.

ELIGIBLE BENCHMARK PLANS

The plans that Arkansas is allowed to consider for purposes of choosing the benchmark plan are the state's largest three small group plans (Blue Cross Blue Shield PPO (PPO); HealthAdvantage POS (HA); QualChoice POS (QCA), the state employee plans (Blue Cross Blue Shield and QualChoice State plans) and the state's three largest federal plans (Blue Cross Blue Shield and QualChoice Federal plans) by enrollment. Generally, the small group plans will have a more limited benefit and the federal plans will have the richest benefit. Accordingly, the premiums associated with each of these plans reflect the benefit levels as well. Individuals purchasing inside the Exchange will receive subsidies on a sliding scale to cover part or all of these premiums if their income is between 100% to 400% of the federal poverty level. Additionally, the federal government has determined that subsidies will not be available for those whose income is less than 100% of the federal poverty level if a state chooses not to expand Medicaid as allowed under the ACA. Affordability will remain an issue if a benefit rich plan is chosen. People who have incomes above 400% of the poverty level or who purchase outside of the Exchange will not have the federal subsidies available to them and will be responsible for the full premium.

COMMITTEE RECOMMENDATIONS

The Plan Management Advisory Committee (PMAC) reviewed the state mandates and the benefit levels offered by the seven plans. PMAC was concerned about the increased cost of premiums if the state or federal plans were chosen due to the richness of the benefit levels. PMAC determined that the small group plans were the most affordable and are popular with many people in the state already being covered by one of the small group plans. Following this decision, PMAC began to evaluate the differences in the small group plans. The three small group plans were mainly separated by the fact that the largest small group plan was an insurer (PPO) that is required to cover in vitro fertilization (IVF) under the state mandate. The other two small group plans were health maintenance organizations (HMO) that are exempted from providing IVF under statute. Because of the federal rules, the choice then presented to the PMAC would force the PMAC to either cause the state to be responsible for the portion of the premium related to IVF if an HMO plan was chosen (assuming that the state mandate was not repealed) or expanding to HMOs the state mandate to cover IVF.

The issue related to the state mandate raised many concerns. If a HMO plan was chosen, the current insurance market in Arkansas would remain similar to how it is today - PPOs would still be required to issue coverage for IVF and HMOs would continue to be exempted. Moreover, the current annual and lifetime limits on IVF of $15,000 would remain in force. Additionally, choosing an HMO plan would give a less expensive premium alternative. However, this option could also potentially lead to adverse selection and could cost the state money. Alternatively, the PPO plan could be chosen, which would mitigate the adverse selection issue and would prevent the state from being charged for the percentage of premium related to the state mandate. Nevertheless, the selection of this plan would then make IVF an EHB that would have to be provided by all plans both on and off of the exchange. It would also make premiums higher for all plans being offered on and off of the Exchange and would remove the annual and lifetime dollar cap on IVF.

The PMAC voted to recommend the PPO plan as the benchmark plan to the Steering Committee in a 16-11 vote. The Steering Committee also weighed these issues and recommended to the Commissioner in a 13-1 vote that the Commissioner choose any of the three small group plans with the understanding that the PPO plan would be the default plan if one of the HMO plans was not chosen. The Steering Committee asked that the Health Benefit Exchange Partnership Division (HBEPD) investigate what the potential costs to the state would be if an HMO plan was chosen so that the Commissioner could also use that information in his consideration.

ACTUARIAL RECOMMENDATIONS

The Exchange worked with two actuaries – one from Arkansas Blue Cross Blue Shield with state IVF plan experience and another from Lewis and Ellis in Dallas. The findings of these actuarial studies estimated the costs to the state could range from $496,080 to $3.8 million.

Another consideration that should be factored into this evaluation is the fact that though the federal government would limit the percentage of premiums related to the state mandate only to specific IVF codes, the use of IVF will increase health utilization in other areas causing an increase in premiums. This is because IVF, specifically if low dollar limits are imposed, would encourage potential parents to implant more than one embryo. This would lead to an increase in multiple births and continuing health costs related to neonatal costs and costs associated with caring for premature children that often continue over the course of the child's life. Because of this, the PPO plans would appear to have a higher cost for providing health coverage than the HMO plans which may make them appear less attractive overall.

RECOMMENDATION: HMO Plan

It is the recommendation of the HBEPD based upon the information that has been gathered, and balancing the comprehensiveness, benefits of the plans, the health care needs of the Arkansas population, the potential that the State may be required to defray the cost of health care plans, the capacity of the carriers within the state to service the EHBs, the expected impact on the population of the State of Arkansas, and the work and recommendation of the PMAC and Steering Committee that one of the two HMO plans be chosen as the essential health benefit benchmark plan.

COMPARISON OF HMO PLANS

The two eligible small group HMO plans are the HealthAdvantage POS plan (HA) and the QualChoice POS plan (QCA). The two plans are substantially identical in their offerings. However, to the extent that there are differences between the plans, the HBEPD has outlined these in the following chart and noted the differences between them. It should also be noted that the mental health benefit provided for under the QCA plan is offered as a rider. Riders are only allowed to be used if they are "commonly purchased." CCIIO has not defined the term, "commonly purchased," but intends to do so in future regulations. The Exchange has been advised by CCIIO that this term will require the Exchange to perform a calculation to show the number of people who had purchased the underlying policy as compared to the number of people who purchased the mental health rider and other riders offered with the policy. The Mental Health and Substance Abuse Treatment rider would not be considered "commonly purchased" if the number of people that purchased the mental health rider was lower than for the other purchased riders or policy in general.

<u>Mental Health</u>

The PPO plan and the HA plan both limit inpatient treatment to 7 days per calendar year and outpatient treatment to 30 days per calendar year. QCA does not limit the number of treatments within the policy. However, the treating healthcare provider must submit a treatment plan that includes the anticipated frequency and duration of treatment. Moreover, residential treatment is

not covered by the QCA policies. All of the small group policies require inpatient treatment to be at a facility licensed as a hospital. Because of the treatment limitations, the PPO plan and the HA plan are not being offered at parity as is required under the mental health parity law. Therefore, if the PPO plan or the HA plan is selected, it is the finding of the HBEPD that the Mental Health and Substance Abuse Treatment benefit is not sufficient to meet the requirements under federal law and the mental health and substance abuse treatment benefit would need to be supplemented from one of the other benchmark plans.

The federal policies do not mention any limits within the mental health and substance abuse treatment benefit section and are substantially identical. They note that either a calendar year deductible or copay will apply. Additionally, if the treatment requires an inpatient hospital stay, precertification is required. Failure to obtain precertification will result in a $500 penalty. Otherwise, all professional services by licensed professional mental health and substance abuse practitioners are covered when acting within the scope of their license. The QCA federal policy offers additional benefit in this area by expanding coverage to halfway houses and other residential facilities otherwise excluded under the Blue Cross Blue Shield federal policy.

Preventive Benefits

As related to preventative benefits, all of the small group plans are required to offer A&B services. Therefore, there is little difference between them. From reviewing the HA and QCA policies, it appears that there may be seven differences between what is covered under the policies. Of these, QCA offers a slightly stronger benefit as related to Tobacco Cessation and Rh Screenings. However, HA offers a better benefit as to Chemopreventative medicine counseling for women at high risk of breast cancer, nutrition counseling, chlamydia infection, HIV and STI counseling.

Further, the policies show that the benefits are similar. Of the differences listed below, the main differences appear between the limits on Home Health Services, Skilled Nursing Facility Services, Organ Transplant Services and Medical Foods. HA's benefits are greater on the first three listed differences by providing 30 additional days for Skilled Nursing Facility Services as compared to QCA, 10 additional days for Home Health, and not requiring prior authorization for cornea and kidney transplants. However, QCA's policy does not limit the amount of medical foods after the first $2,400. Medical foods is not covered under the HA plan.

Therefore, it would appear that the plans are generally similar. However, to the extent that the plans differ in thirteen different areas, HA would appear to offer stronger benefits in 8 of those areas. QCA would appear to be stronger in 4 areas, including mental health.

	Health Advantage POS Plan	Qual Choice POS	Differences
	Psychiatric Conditions and Substance Abuse Services - IP limited to 7 days per calendar year; OP limited to 30 visits per calendar year; Substance abuse limit of 2 admissions/lifetime does not apply to HA	**Mental Health and Substance Use Disorder** - Covered under MH Parity and under separate rider; for small group this is limited to 10 visits/days per calendar year. Requires treating physician to submit a treatment plan with diagnosis, intended therapeutic process, expectation of treatment and anticipated frequency of treatment.	The QCA Rider is the only option that covers mental health at parity as is required by federal law under the ACA.
	Durable Medical Equipment - Medical supplies related to DME limited to 90 day supply per purchase	**Durable Medical Equipment** - $2,000 max per year	This is essentially equal. If QCA is chosen, the dollar limit will go away and it is expected that QCA would otherwise limit.
	Prosthetic and Orthotic Devices - for treatment of condition arising from illness or accidental injury	**Prosthetic and Orthotic Devices** - Covered with specific exclusions. QualChoice does not cover replacement or associated services more frequently than one time every three years, unless medically necessary due to growth, etc.	It appears that QCA may offer a better benefit here as it is similar to Medicaid.
	SNF Services - limited to 60 days per calendar year	**SNF Services** - Limited to 30 days per calendar year.	Health Advantage offers a better benefit here.
	Home Health – limited to 50 visits per calendar year	**Home Health –** limited to 40 visits per calendar year	Health Advantage offers a better benefit here.
	Organ Transplant Services - PA required except for cornea and kidney transplants	**Organ Transplant Services** - PA required for all transplants	Essentially equal, but HealthAdvantage may be considered a better benefit as Physician approval is not required for cornea or kidney transplants.
	Medical Foods and Low Protein Modified Foods - none	**Medical Foods** - the benefit is unlimited after 1st $2,400	QCA offers a better benefit here
PREVENTIVE SERVICES			
	Health Advantage POS	**QualChoice POS**	**Differences**
Breast Cancer Preventive Medication	Chemoprevention counseling by clinicians for women at high risk of breast cancer	Standard member cost share based on tier placement	Health Advantage offers a stronger benefit
Chlamydia Infection	Covered up to 2X per year	annually	Health Advantage offers a stronger benefit

HIV Counseling and Screening	may be billed 2X yearly	annually	Health Advantage offers a stronger benefit
nutrition counseling adults	Intensive counseling with hyperlipidemia limited to 8 visits per contract or calendar year	covered 4X annually	Health Advantage offers a stronger benefit
RH Screenings	Up to 2 per year	covered during pregnancy	Probably equal. However, if multiple pregnancies occur in a one year period, QCA would offer the stronger benefit.
STI Counseling	6 per year	annually	Health Advantage offers a stronger benefit
Tobacco Use	Screening and counseling 3X per year for all adults; 4X per year for pregnant women	annually; Additional "Kick the Nic" campaign 2X per year with medication vouchers.	Health Advantage offers more screening and counseling. However, QCA offers medication vouchers. Current research indicates that counseling and medication should be provided simultaneously. Therefore, QCA may offer the better benefit through its "Kick the Nic" program.

RECOMMENDATION OF HMO SMALL GROUP PLAN

It is the recommendation of the HBEPD that if an HMO product is chosen, that the HA policy be chosen. Though the differences between the preventative benefits are not considerable, HA offers a slightly stronger benefit in the majority of those areas.

Because it is the finding of the HBEPD that the mental health benefit offered within the HA policy is not sufficient to meet Mental Health Parity requirements under federal law, this benefit is required to be supplemented by one of the other eligible benchmark plans. The HBEPD recommends based upon the analysis of the federal plans that the QCA federal policy be used to supplement the mental health benefit.

NOTATION AS TO SUPPLEMENTATION RELATED TO HABILITATIVE SERVICES

CCIIO has announced that the state will make all decisions related to supplementation of the health plans with some limited exceptions. States have been waiting to see what definition CCIIO will choose to implement with regard to habilitative services prior to choosing how to implement the requirement for supplementation. CCIIO has decided that the carriers will choose how to supplement their plans in this regard and that the state will have the power of rejecting

the filing if habilitative is not covered in a way that follows the spirit of the federal law. Their reasoning is that this is to give the most flexibility to the states and plans to cover a benefit that has never been defined before now.

RECOMMENDATION FOR PEDIATRIC DENTAL AND PEDIATRIC VISION SUPPLEMENTATION

None of the three small group plans offer coverage for pediatric vision or dental services. Therefore, the state was allowed to consider the pediatric vision and dental as contained within the federal plan. The State CHIP plan is also an option for pediatric dental. Because there is only one choice for the pediatric vision plan for supplementation, the PMAC and Steering Committee did not make a formal recommendation as to the pediatric vision supplementation piece. The HBEPD would recommend that the Commissioner adopt the federal plan pediatric vision plan with greatest enrollment (Blue Cross Blue Shield Vision High) to supplement the small group plans.
The question that arose with the pediatric dental consideration was whether orthodontia was required to be covered or not. Currently, rules have not been developed to answer this question. A bulletin was released in early 2012 that indicates medical orthodontia may be required to be covered. CCIIO addressed this question by telling the states that we could either choose to cover or not cover orthodontia.

The PMAC considered this issue by taking into account the cost of orthodontia and the fact that orthodontia is mainly utilized for cosmetic reasons. Of the two plans that are allowed to be considered, the federal plan offers full orthodontia coverage and the CHIP plan does not cover orthodontia at all. The PMAC seemed interested in a requirement for medical orthodontia. However, because there is not a benchmark plan that offers the limited pediatric dental benefit of medical orthodontia and because the majority of orthodontia treatment is cosmetic, the PMAC recommended in a unanimous vote that the CHIP pediatric dental benefit be used to supplement the benchmark plan. This was affirmed by a unanimous vote of the Steering Committee. Thus, it is the recommendation of HBEPD that the Commissioner supplement pediatric dental with the CHIP pediatric dental benefit.

Any questions regarding this Directive should be directed to the Legal Division of the Arkansas Insurance Department at 501-371-2820 or via e-mail at insurance.legal@arkansas.gov.

JAY BRADFORD
ARKANSAS INSURANCE COMMISSIONER

September 21, 2012
DATE